PATIENT HEALTH QUESTIONNAIRE

Patient name (please print)	Date of Birth	Patient Signature	Date today
_____	___/___/___	_____	___/___/___

❑ I have no known allergies to medications.

I am allergic to these medications: _____ Reaction: _____
_____ Reaction: _____

What is the main reason for your visit today? _____

Are you currently under the care of any other doctors? Please list them: _____

Which pharmacy to you prefer? Name: _____ Location: _____

*As you review the following list, please **check** any problems or conditions that you are experiencing or have experienced.*

- ❑ Anemia
- ❑ Anxiety
- ❑ Asthma
- ❑ Back pain
- ❑ Bleeding disorder
- ❑ Blood in stool
- ❑ Blood Transfusions
- ❑ Cataracts
- ❑ Chest pain
- ❑ Depression
- ❑ Diabetes ❑type 1 ❑ type 2
- ❑ Eating disorder
- ❑ Emphysema/COPD
- ❑ Epilepsy / Seizures
- ❑ Fainting
- ❑ Female: # miscarriages ____
- ❑ Female: # pregnancies ____
- ❑ Female: Abnormal Mammogram
- ❑ Female: Abnormal Pap smear
- ❑ Female: endometriosis
- ❑ Female: first day of last menstrual period_____
- ❑ Female: irregular periods
- ❑ Fibromyalgia
- ❑ Frequent Urinary Tract Infections
- ❑ Glaucoma
- ❑ Gout
- ❑ Headaches
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Palpitations
- ❑ Heart Valve Problems
- ❑ Hemorrhoids
- ❑ Hepatitis ❑A ❑B ❑C
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Immune Deficiency
- ❑ Indigestion/Heartburn
- ❑ Insomnia / Sleep Problems
- ❑ Joint pain
- ❑ Kidney Stones
- ❑ Longstanding Fatigue
- ❑ Lupus
- ❑ Male: prostate problems
- ❑ Male: testicular pain
- ❑ Migraines
- ❑ Mini stroke/ TIA
- ❑ Multiple Sclerosis
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Paralysis
- ❑ Rheumatoid Arthritis
- ❑ Seasonal Allergies
- ❑ Sexually transmitted/Venereal disease
- ❑ Shortness of Breath
- ❑ Skin Cancer
- ❑ Stroke
- ❑ Thyroid disorder
- ❑ Tuberculosis (TB)
- ❑ Urine incontinence
- ❑ Valley Fever
- ❑ Other:

_____
_____

Surgeries:	Year		Year
Tonsils Removed		Heart Bypass	
Appendix Removed		Heart stent placed	
Gallbladder Removed		Gastric Bypass/Lapband	
Uterus Removed		Back	
Ovaries Removed		Knee	
Prostate Removed		Shoulder	
Vasectomy		Other:	

Family History:	Dad	Mom	Sibs
Diabetes			
Thyroid disorders			
Mental Illness			
Heart Attack /Heart Diseas			
High Blood Pressure			
Stroke			
Aneurysm			
Cancer (type)			
Other:			

Risk Factors/Social History:		Quit Date	How Often?	How much at a time?	Type?
Alcohol use	❑ No ❑ Yes				
Tobacco use	❑ No ❑ Yes				
Exercise	❑ No ❑ Yes				
Caffeine/Energy Drinks	❑ No ❑ Yes				
Recreational drug use	❑ No ❑ Yes				

Medications you currently use:	Strength:	How many at once?	How many times per day?

If you take a lot of medications, please bring a comprehensive list on a separate sheet of paper AND bring your medication bottles with you to your first appointment.